COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

ADULT AND OLDER ADULT MENTAL HEALTH SERVICES
CHILDREN'S MENTAL HEALTH SERVICES
ALCOHOL AND DRUG SERVICES

CHARTER AND CONSENSUS DOCUMENT

CO-OCCURRING PSYCHIATRIC AND SUBSTANCE ABUSE DISORDERS

March 24,2003

RODGER LUM, Ph.D.
Health and Human Services Agency, Director

MARK REFOWITZ
Adult and Older Adult, Deputy Director

ALFREDO AGUIRRE
Children Mental Health Services, Deputy Director

AL MEDINA
Alcohol and Drug Program Administrator

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

VISION

All San Diego County residents will be healthy, safe and self-sufficient, and contribute to the overall well-being and quality of life of the community.

MISSION

Through partnerships and emphasizing prevention, assure a healthier community and access to needed services, while promoting self-reliance and personal responsibility.

GUIDING PRINCIPLES

1. Consolidate and integrate programs.
2. Establish regionalized community-based service delivery systems focused on Customer Service.
3. Value employees, our most important resource.
4. Ensure all activities are outcome driven.
5. Achieve a smaller governmental bureaucracy.
6. Assure fiscal responsibility and integrity.
7. Expand community collaborative efforts into full partnerships.

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

ADULT AND OLDER ADULT MENTAL HEALTH SERVICES

CHILDREN MENTAL HEALTH SERVICES

ALCOHOL AND DRUG SERVICES

CHARTER AND CONSENSUS DOCUMENT

CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS

Overview

The County of San Diego, Health and Human Services Agency, (HHSA), is committed to quality of care for all clients served in the public health system. Individuals with co-occurring psychiatric and substance abuse disorders in San Diego County are recognized as a population with poor outcomes in multiple clinical domains and whose treatment costs are higher. They are underserved in both mental health and substance abuse treatment settings, with resulting overutilization of resources in the criminal justice system, the primary health care system, the homeless shelter system, and the child protective system. In addition to having poor outcomes and high costs, individuals with co-occurring disorders are sufficiently prevalent in all behavioral health settings that they can be considered an expectation, rather than an exception. "Clinical" in its usage throughout this document is understood to encompass alcohol and drug treatment and recovery modalities.

In order to provide more welcoming, accessible, integrated, continuous, and comprehensive services to these individuals, the following entities in San Diego County, Health and Human Services Agency, (HHSA), Adult and Older Adult Mental Health Services, (AOAMHS), Children's Mental Health Services (CMHS), Alcohol and Drug Services (ADS), with support of both the Mental Health and Substance Abuse Advisory Boards, have agreed to adopt the Comprehensive, Continuous, Integrated System of Care (CCISC) model for designing systems change to improve outcomes within the context of existing resources. This model is based on the following eight clinical consensus best practice principles (Minkoff, 1998, 2000) which espouse an integrated clinical treatment philosophy that makes sense from the perspective of both the mental health system and the substance disorder treatment system:

1. Dual diagnosis is an expectation, not an exception. This expectation has to be included in every aspect of system planning, program design, clinical procedure, substance abuse recovery, treatment, case management, and aftercare services,

counselor and clinician competency, and incorporated in a welcoming manner into every clinical and treatment recovery contact.

2. The core of treatment success in any setting is the availability of empathic, hopeful treatment and recovery relationships that provide integrated treatment, coordination and continuity of care across multiple treatment episodes. Integrated treatment is defined to include collaborative relationships formed between programs to address and treat both disorders.

3. Assignment of responsibility for provision of such relationships can be determined using the four quadrant national consensus model for system level planning, based on high and low severity of the psychiatric and substance disorder.

4. Within the context of any treatment relationship, case management and care, based on the client's impairment or disability, must be balanced with empathic detachment, confrontation, contracting, and opportunity for contingent learning, based on the client's goals and strengths, and availability of appropriate contingencies. A comprehensive system of care will have a range of programs that provide this balance in different ways.

5. When mental illnesses and substance abuse disorders co-exist, each disorder should be considered of equal importance, and integrated dual primary treatment is required.

6. Mental illness and substance abuse or dependence are both examples of chronic, biopsychosocial disorders that can be understood using a disease and recovery model. Each disorder has parallel phases of recovery (acute stabilization, engagement and motivational enhancement, prolonged stabilization and relapse prevention, rehabilitation and growth) and stages of change. Treatment must be matched not only to diagnosis, but also to phase of recovery and stage of change. Appropriately matched interventions may occur at almost any level of care.

7. Consequently, there is no one correct dual diagnosis program or intervention. For each individual, the proper treatment must be matched according to quadrant, diagnosis, disability, strengths/supports, problems/contingencies, phase of recovery, stage of change, and assessment of level of care. In a CCISC, all programs are dual diagnosis programs that at least meet minimum criteria of dual diagnosis capability, but each program has a different "job", that is matched, using the above model, to a specific cohort of patients, clients, or participants.

8. Similarly, outcomes must be also individualized, including reduction in damaging consequences, movement through stages of change, changes in type, frequency, and amounts of substance use or psychiatric symptoms, improvement in specific disease management skills and treatment adherence.

Using these principles, we have agreed to implement a CCISC in San Diego County, HHSA, with the following four core characteristics:

1. The CCISC requires participation from all components of the mental health and alcohol and drug service system, with expectation of achieving, at minimum, Dual

Diagnosis Capability standards (and in some instances Dual Diagnosis Enhanced capacity), and planning services to respond to the needs of an appropriately matched cohort of dual diagnosis patients, clients, or participants.

2. The CCISC will be implemented initially with no new funding, within the context of existing treatment operational resources, by maximizing the capacity to provide integrated treatment proactively within each single funding stream, contract, and service code.

3. The CCISC will incorporate utilization of the full range of evidence-based best practices and clinical consensus best practices for individuals with psychiatric and substance abuse disorders, and promote integration of appropriately matched best practice treatments for individuals with co-occurring disorders. "Clinical" in its usage throughout this document is understood to encompass alcohol and drug treatment and recovery modalities.

4. The CCISC will incorporate an integrated treatment philosophy and common language using the eight principles listed above, and develop specific strategies to implement clinical programs, policies, and practices in accordance with the principles throughout the system of care.

Action Plan

In the first year of implementation, all Health and Human Services Agency (HHSA) programs and contractor agency programs participating in this initiative will agree to implement the following action steps. All programs and/or agencies participating in the train-the-trainer initiative, whether voluntarily or by contract requirement, must sign this charter and agree to this action plan.

1. Adopt this charter as an official policy statement of the program and/or parent agency, with approval of Board of Directors or similar governing body as appropriate. Circulate the approved charter document to all staff, and provide training to all staff regarding the principles and the CCISC model.
2. Assign appropriately empowered administrative and clinical staff to participate in San Diego County's integrated system planning and program development activities.
3. Adopt the goal of achieving dual diagnosis capability as part of the program and/or parent agency's short and long range strategic planning and quality improvement processes.
4. Participate in the self-survey using the COMPASS instrument at six month intervals to evaluate the current status of dual diagnosis capability.
5. Develop a program specific action plan outlining measurable changes at the agency level, the program level, the clinical practice level, and the clinician competency level to move toward dual diagnosis capability. Monitor the progress of the action plan at six month intervals. Participate in system wide training and technical assistance with regard to implementation of the action plan.

6. Participate in system wide efforts to improve identification and reporting of individuals with co-occurring disorders by incorporating program specific improvements in screening and data capture in the action planning process.
7. Participate in system wide efforts to improve welcoming access for individuals with co-occurring disorders by adopting program specific welcoming policies, materials, and expected staff competencies.
8. Assign staff to participate in system wide efforts to develop dual diagnosis capability standards, and systemic policies and procedures to support welcoming access in both emergency and routine situations.
9. Assign appropriate clinical and administrative leadership to participate in interagency care coordination meetings as they are developed and organized.
10. Participate in system wide efforts (e.g., Co-occurring Disorders Training Subcommittee) to identify required attitudes, values, knowledge, and skills for all clinicians and direct service staff regarding co-occurring disorders, and adopt the goal of dual diagnosis competency for all clinicians and direct staff as part of the agency's long range plan.
11. Participate in clinician and staff competency self survey using the CODECAT at six month intervals, and use the findings to develop an agency and/or program specific training plan.
12. Identify appropriate clinical supervisory and administrative staff to participate as trainers in the system wide train-the-trainer initiative, to assume responsibility for implementation of the agency's or program's training plan, and assist in tool administration and implementation of the agency's or program's dual diagnosis capability action plan.

This document is hereby ratified by the following signatories:

Rodger Lum, Ph.D.
Health and Human Services Agency, Director

Mark Refowitz
Adult and Older Adult, Deputy Director

Alfredo Aguirre
Children's Mental Health Services, Deputy Director

Al Medina
Alcohol and Drug Program Administrator